ELIGIBILITY /COVERED FUNCTION ISSUE

Issue discussion of the applicability of the eligibility transaction to DSHS programs.

Questions and Short Answers:

(1) Does the eligibility transaction occur now in the "social service" parts of the health plan?

Not Always.

(2) The health plan must respond to eligibility inquiries. What system will support the eligibility transaction?

In order to respond to eligibility inquiries, the capacity system must contain enrollment data. The system must contain service specific information if a service specific response is necessary due to program's current functionality or desired by program. Other systems may also need to contain this information.

Background:

HIPAA defines eligibility inquiry and response at 162.1201:
(a) an inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee:

(1) eligibility to receive health care under the health plan.
(2) Coverage of health care under the health plan
(3) Benefits associated with the benefit plan

The 270/271 Implementation guides at 1.3.2 state that the information source (inquiry receiver) is typically the insurer, or payer. In a managed care environment, the information source could possibly be a primary care physician or gateway provider. Regardless of the information source's actual role, they are the entity who maintains the information regarding the patient's coverage. The information receiver (inquirer) is typically the medical service provider (e.g. physician, hospital, lab, etc.). The information receiver could also be another insurer or payer when they are attempting to verify other insurance coverage for their members… [or] an employer inquiring on coverage of an employee.

In a typical health care situation or "medical model" this transfer occurs when:

a) A provider, or insurer, or employer sends an inquiry about insurance coverage to a health plan or payer.
b) Medicaid send inquiries about other insurance coverage in order to determine if there is any third party liability
c) Medicare and Medicaid exchange eligibility inquiries to determine coverage…

Issues:

(1) Social service programs have not traditionally defined a distinct "plan" that eligible clients are "enrolled" in. This question was addressed in the enrollment issue paper. The social service program must decide the extent of their plan or plans in order to determine when, if at all, enrollment occurs.

(2) The social service model combines the roles of payer and "gateway provider" in a social worker/case manager. Thus, the client does not typically select services without the social worker/case manager. In the social service model a case manager, employed by the payer, determines program enrollment or eligibility and also determines the services needed by the client. The client is then sent to the service provider with appropriate authorization information, or the service provider is contacted by the case manager to arrange for the client service.

Therefore, a provider would not routinely inquire of a social service plan as to eligibility because the provider does not see the client until the client has received authorization from the plan. So, either the client or the provider already has the eligibility information.

However, there are inquiries to the social service plan about coverage or benefits:

- A client (or a minor or disabled client's guardian) may not bring the appropriate authorization information to the provider. A provider would then contact the social worker/case manager to verify service eligibility.
- A client may be sent to a service provider prior to all appropriate authorization being completed. The provider subsequently contacts the social worker/case manager to obtain or verify that the appropriate authorization has been completed.
- A provider may contact the case manager to verify the number of service units or hours authorized for a specific client.
- A provider may contact the case manager to inquire about other services available to the client, or request additional units or hours of service (this could also be prior authorization).
- A provider or other payer may inquire about spend down limits, maximum benefit levels, co-pays, client responsibility amounts, or other or partial insurance application or levels.
- Some Medicaid eligibility can vary from day to day or week to week. If Medicaid is involved, a provider or other insurer may inquire about coverage for a specific event or time period.

Currently, these inquiries are mostly conducted by telephone, in writing, or in person.

Analysis:

HIPAA Requirements. Section 1171(5)(E) of the Social Security Act, as enacted by HIPAA, identifies the State Medicaid programs as health plans, which therefore must be capable of receiving, processing, and sending standard transactions electronically. Additionally, any other group or individual plan that pays the cost of medical care is a covered health plan. Health plans must comply with the transactions standards, including eligibility described above by October 16, 2002.

There is no requirement that internal information systems maintain data in accordance with the standards. However, Medicaid programs will need the capacity to process standard claim, encounter, enrollment, eligibility, remittance advice, and other transactions. (FAQ quote).

Real time vs. Batch transaction: A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction. 162.925.
270/271 Implementation Guide 1.3.3: Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute.

DSHS conducts eligibility inquiries in real time, via the telephone and electronically now, therefore it must maintain that capability in a HIPAA compliant way.

Capacity System: DSHS sends and responds to eligibility inquiries. The DSHS health plan must have the capacity to conduct electronic eligibility inquiry and response in a HIPAA compliant way. DSHS leadership decided that there would be one capacity system, MMIS

Additional systems: Other payment systems within DSHS would not be required to conduct electronic eligibility inquiry or response. However, those systems that do conduct electronic eligibility must do so in a HIPAA compliant way.

Internal Impact: The capacity system must be sent information with which to respond to eligibility inquiries. See Enrollment discussion for details. The internal impact appears fairly minimal, as sending the data to the internal system is not a HIPAA transaction and the data is already sent to payment systems. Discussions are already under way with the ACES system owners about what content change might be necessary because most of the enrollment data originates there. Enrollment and Eligibility TAG discussions are under way regarding technical solutions for the capacity system.

External Impact: If systems, in addition to the capacity system are utilized, providers need to be educated about where to route their inquiries.

Decisions and Consequences:

What system contains your administration's or division's plan information now (if defined at all)? Reference the enrollment discussion for definition of your plan.

Where is information about client eligibility (enrollment data) kept?

How do you respond to provider inquiries about client services or eligibility now?

- Paper/telephone/in person/ computer
- Single inquiry or a batch of inquiries; length of time
- Response is yes/no client eligible for plan, service level detail, other

How will you maintain the same or higher level of service using the HIPAA compliant EDI?

If a business associate has this information, how will they respond? (ie. Managed care environment or perhaps county/other)

Log privacy/security concerns – what business rules do you currently apply when answering a provider question?

- Can any provider inquire about any client; only some clients; only some providers; no clients.

POLICY TAG DISCUSSION:

Q: Can't the payment systems just respond with information they already contain, (ie: MMIS has Medicaid eligibility/SSPS has service authorization)?

Currently, neither payment system contains adequate data for response to "social service plans". This is because social service plans have never been defined before, and not associated with client eligibility.

MMIS can access data on Medicaid NC eligibility. SSPS can provide data on a specific service that is authorized. No system currently has data to respond to a generic inquiry like: Is John X eligible for the DD Plan/Services? This is the minimum inquiry/response capability required by HIPAA.
If a program currently responds to a higher level of inquiry such as: Is John X eligible for five therapy services under ABC program? Then, HIPAA requires electronic response to this as well.

Q: What is "real time" definition in HIPAA terms? Is it a description of computer to computer interaction only, or can there be human intervention?

CFR p. 50340: … One commenter said that the 270 requires a 271 response to every record, a one-to-one correspondence. The commenter recommended that the one-to-one response be negotiable between the parties that have a contract to exchange information.
Response: A one-to-one correspondence to every record is not required. The 270/271 transactions sets were built so that trading partners could use them in real time or batch mode. We agree that negotiation must occur between trading partners… regarding processing limits.

Transactions FAQ: What level of service is required to be provided under HIPAA when an entity implements batch and/or real time submission of a standard transaction?
A: 45 CFR 162.925 states "a health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction." If the standard transaction (e.g., ASC X12N 270/271) is offered in a batch (non-interactive) mode, the health plan has to offer the same or higher level of service as it did for a batch mode of transaction before the standards were implemented by the plan. If a health plan offers the transaction in a real time (interactive) mode, the level of service has to be at least equal to the previously offered level for a real time mode of transaction. If a transaction is offered through Direct Data Entry (DDE), the level of service, again, has to be at least equal to the level offered for the DDE transaction before implementation of the HIPAA standard.

Q: Can any provider get access to eligibility information about clients? This poses a problem for several divisions with privacy laws restriction information.

The plan must respond to inquiries, but if we have business rules restricting access to or release of information to specified providers, those can be followed. The answer in a 271 would be something like "Not authorized to provide information". Francine K. indicates there are already several possible responses that appear to fit such as "provider type does not match service".

CFR p. 50340: … One commenter suggest that we clarify the requirements to clearly state that while health plans must implement the 270/271 …they are not required to respond to all requests sent in the 270.
Response: We do not agree. A health plan may not reject a standard transaction because it contains information the health plan does not want. This principle applies to the data elements of all transactions in this rule. Health plans must accept a complete 270 and must respond with all applicable responses that are included in the 271. If health plans can arbitrarily respond or not respond to a standard transaction, then the cost saving effect of using the standards will be blunted by a requirement to negotiate the aspects of every trading partner.

Q: What is the technical proposal for the front end (capacity system) to get the data?

Francine K. indicated this is what the Eligibility/Enrollment (EE) TAG, lead by Paul Price, is working through. Participation is highly encouraged. Technical issues should be followed up with system owners or TAGs. Francine then gave an overview of what she knew:

If you send the data now, behind the scenes, this data would also be sent to front end. So, no business change. Except: where HIPAA requires new data elements. If you don't currently send any data, (like A-19 provider and client receives no other services) we would have to enter data into the system through a direct entry. Francine will take this issue to EE TAG- make sure to review access built in for data entry.